DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **03-32**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **July 1, 2003**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.204	7. FEDERAL BUDGET IMPACT: a. **FFY 07/01/03 – 09/30/03 $ 6,000,000.** b. **FFY 10/01/03 – 09/30/04 $ 24,000,000.**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B, Pages 2(c)(i), 2(g), 2(g)(i), 2(g)(ii), 2(g)(iii), and 2(g)(iv)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B, Page 2(c)(i)** **New pages are Attachment 4.19-B, Pages 2(g), 2(g)(i), 2(g)(ii), 2(g)(iii) and 2(g)(iv).**

10. SUBJECT OF AMENDMENT:
Non-Institutional Services: Diagnostic & Treatment Centers

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: Kathryn Kuhmerker	16. RETURN TO: **New York State Department of Health, Corning Tower, Empire State Plaza, Room 1466** **Albany, New York 12237**
13. TYPED NAME: **Kathryn Kuhmerker**	
14. TITLE: **Deputy Commissioner** **Department of Health**	
15. DATE SUBMITTED: September 26, 2003	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: JUN 18 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2003	20. SIGNATURE OF REGIONAL OFFICIAL: Sue Kelly
21. TYPED NAME: Sue Kelly	22. TITLE: Associate Regional Administrator Division of Medicaid and State Operations

23. REMARKS:

Originally submitted pages 2(c)(i) & 2(g) were revised in accordance by State letters of 3/19/04 and 6/4/04.

OFFICIAL

New York
2(c)(i)

Attachment 4.19-B
SPA #03-32
(07/03)

Comprehensive Primary Care Services

Voluntary Non-Profit and Publicly Sponsored Diagnostic and Treatment Centers Certified Under Article 28 of the Public Health Law

An allowance will be established annually and added to Medicaid rates of payment for certified agencies, which can demonstrate a financial shortfall as a result of providing comprehensive primary care services to a disproportionate share of uninsured low-income patients. Losses will be calculated by applying the current Medicaid payment rate to base year units of service to uninsured low-income patients, offset by related-out-of-pocket patient receipts, subsidy grants and State aid deficit financing to publicly-sponsored facilities. An annual agency loss coverage will be established by applying calculated losses to a nominal loss coverage ratio scale within the limits of pool allocations to public and non-public agencies. Notwithstanding any inconsistent provisions of this paragraph, adjustments to rates of payment for diagnostic and treatment centers determined in accordance with this paragraph shall apply only for services provided on or before December 31, 1996.

The methodology described in the following paragraphs pertains to diagnostic and treatment centers, which received an allowance for financing losses resulting from the provision of comprehensive primary care services to a disproportionate share of uninsured low-income patients during the period from July 1, 1990 through December 31, 1996. This allowance is described in the previous paragraph. For the period July 1, 2003 through December 31, 2003, qualified diagnostic and treatment centers shall receive an uncompensated care rate adjustment of not less than one-half the amount that would have been received for any losses associated with the delivery of bad debt and charity care for calendar year 1995.

For the period January 1, 2004 through December 31, 2004, each such diagnostic and treatment center shall receive an uncompensated care rate adjustment of not less than twice the amount calculated pursuant to the above paragraph. For the period January 1, 2005 through June 30, 2005, each such diagnostic and treatment center shall receive an uncompensated care rate adjustment of not less than the amount calculated pursuant to the above paragraph.

Any residual amount allocated for distribution to a classification of diagnostic and treatment centers in accordance with the above shall be reallocated by the Commissioner for distributions to the other classifications based on remaining need.

TN 03-32 Approval Date JUN 18 2004
Supersedes TN 96-25 Effective Date JUL 01 2003

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Adjustments to rates of payment made pursuant to this section may be added to rates of payment or made as aggregate payments to eligible diagnostic and treatment centers and shall not be subject to subsequent adjustment or reconciliation.

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Comprehensive Diagnostic And Treatment Center Indigent Care Program

For periods on and after July 1, 2003, the Commissioner of Health shall adjust medical assistance rates of payment to assist in meeting losses resulting from uncompensated care.

Eligible diagnostic and treatment centers shall mean voluntary non-profit and publicly sponsored diagnostic and treatment centers providing a comprehensive range of primary health care services which can demonstrate losses from disproportionate share of uncompensated care during a base period two years prior to the grant period.

Uncompensated care need means losses from reported self-pay and free visits multiplied by the facility's medical assistance payment rate for the applicable distribution year, offset by payments received from such patients during the reporting period.

A diagnostic and treatment center qualifying for a distribution or a rate adjustment shall provide assurances satisfactory to the Commissioner that it shall undertake reasonable efforts to maintain financial support from community and public funding sources and reasonable efforts to collect payments for services from third-party insurance payors, governmental payors and self-paying patients.

To be eligible for an allocation of funds or a rate adjustment, a diagnostic and treatment center must provide a comprehensive range of primary health care services and must demonstrate that a minimum of five percent of total clinic visits reported during the applicable base year period were to uninsured individuals. The Commissioner may retrospectively reduce the allocations of funds or the rate adjustments to a diagnostic and treatment center if it is determined that provider management actions or decisions have caused a significant reduction for the applicable period in the delivery of comprehensive primary health care services to uncompensated care residents of the community.

New York
2(g)(i)

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Attachment 4.19-B
SPA #03-32
(07/03)

For periods on and after July 1, 2003, funds shall be made available for adjustments to rates of payments for the following categories of eligible comprehensive voluntary diagnostic and treatment centers (D&TCs) for the following periods in the following aggregate amounts:

Voluntary Non-Profit D&TCs

A. For the period July 1, 2003 through December 31, 2003, up to seven million five hundred thousand dollars;
B. For the period January 1, 2004 through December 31, 2004, up to fifteen million dollars;
C. For the period January 1, 2005 through June 30, 2005, up to seven million five hundred thousand dollars.

Public D&TCs, other than those operated by the New York City Health and Hospitals Corp.

A. For the period July 1, 2003 through December 31, 2003, up to nine million dollars;
B. For the period January 1, 2004 through December 31, 2004, up to eighteen million dollars;
C. For the period January 1, 2005 through June 30, 2005, up to nine million dollars.

Public D&TCs Operated by the New York City Health and Hospitals Corporation

A. For the period July 1, 2003 through December 31, 2003, up to six million dollars;
B. For the period January 1, 2004 through December 31, 2004, up to twelve million dollars;
C. For the period January 1, 2005 through June 30, 2005, up to six million dollars.

IN 03-32

Superseded TN NEW

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Methodology

A nominal payment amount for the financing of losses associated with the delivery of uncompensated care will be established for each eligible diagnostic and treatment center in each of the following categories; voluntary non-profit Diagnostic and Treatment Centers (D&TCs), public D&TCs other than those operated by the New York City Health And Hospitals Corporation, and public D&TCs operated by the New York City Health And Hospitals Corporation. The nominal payment amount shall be calculated as the sum of the dollars attributable to the application of an incrementally increasing nominal coverage percentage of base year period losses associated with the delivery of uncompensated care for percentage increases in the relationship between base year period eligible uninsured care clinic visits and base year period total clinic visits according to the following scale:

Percent of eligible bad debt and charity care clinic visits to total visits	Percent of nominal financial loss coverage
up to 15%	50%
15-30%	75%
over 30%	100%

The uncompensated care rate adjustments for each eligible diagnostic and treatment center shall be based on the dollar value of the result of the ratio of total funds allocated for distributions for diagnostic and treatment centers within the applicable category to the total statewide nominal payment amounts for all eligible diagnostic and treatment centers within the applicable category applied to the nominal payment amount for each such diagnostic and treatment center.

Adjustments to rates of payment made pursuant to this section may be added to rates of payment or made as aggregate payments to eligible diagnostic and treatment centers and shall not be subject to subsequent adjustment or reconciliation.

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Non-Hospital Based Freestanding or Local Health Department Operated General Medical Clinics

Non-hospital based freestanding or local health department operated general clinics sponsored by municipalities that received state aid for the 1989-90 state fiscal year in support of non-hospital based free-standing or local health department operated general medical clinics shall receive an uncompensated care rate adjustment for the period July 1, 2003 through December 31, 2003, of not less than one-half the amount received in the 1989-90 state fiscal year for general medical clinics.

For the period January 1, 2004 through December 31, 2004, each such eligible general clinic shall receive an uncompensated care rate adjustment of not less than twice the amount calculated pursuant to the previous paragraph.

For the period January 1, 2005 through June 30, 2005, each such eligible general clinic shall receive an uncompensated care rate adjustment of not less than the amount calculated pursuant to the first paragraph.

Adjustments to rates of payment made pursuant to this section may be added to rates of payment or made as aggregate payments to eligible general clinics and shall not be subject to subsequent adjustment or reconciliation.

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New York
2(g)(iv)

Attachment 4.19-B
SPA #03-32
(07/03)

Diagnostic And Treatment Centers With Less Than Two Years Operating Experience

For periods on and after July 1, 2003, funds shall be made available for adjustments to rates of payment for eligible diagnostic and treatment centers with less than two years of operating experience, and diagnostic and treatment centers which have received certificate of need approval on applications which indicate a significant increase in uninsured visits, for the following periods and in the following aggregate amounts:

- For the period July 1, 2003 through December 31, 2003, up to one million five hundred thousand dollars;
- For the period January 1, 2004 through December 31, 2004, up to three million dollars;
- For the period January 1, 2005 through June 30, 2005, up to one million five hundred thousand dollars.

To be eligible for a rate adjustment, a diagnostic and treatment center shall be a voluntary non-profit or publicly sponsored diagnostic and treatment center providing a comprehensive range of primary health care services and be eligible to receive a Medicaid budgeted rate prior to April first of the applicable rate adjustment period after which time, the Department shall issue rate adjustments pursuant to the information provided in this plan for such periods. Rate adjustments made pursuant to this section shall be allocated based upon each eligible facility's proportional share of costs for services rendered to uninsured patients which have otherwise not been used for establishing distributions to the total of all qualifying facilities. For the purposes of this section, costs shall be measured by multiplying each facility's Medicaid budgeted rate by the estimated number of visits reported for services anticipated to be rendered to uninsured patients meeting the aforementioned criteria, less any anticipated patient service revenues received from such uninsured patients, during the applicable rate adjustment period.

Adjustments to rates of payment made pursuant to this section may be added to rates of payment or made as aggregate payments to eligible diagnostic and treatment centers and shall not be subject to subsequent adjustment or reconciliation.

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